

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>BLOOMINGTON SURGERY CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1011 W SECOND ST BLOOMINGTON, IN 47403</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor 33212 Facility #: 005405</p> <p>Type of survey: State Licensure Off-site AAAHC Accreditation Survey Report</p> <p>Date of AAAHC Survey on-site: 1/30-31/2012</p> <p>Date of off-site review: 9/04/2013</p> <p>Based on review of the 01/31/2012 AAAHC Survey Report, it has been determined that Bloomington Surgery Center meets the requirements for ASC Licensure in Indiana for 2012.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE